Claim for Benefits under Energy Employees Occupational Illness Compensation Program Act

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Provide all information requested below. **DO NOT FILL IN SHADED AREAS.**

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OMB Number: 1215-0197
Expiration Date: 8/31/2007

EMPLOYEE INFORMATION

1. Name *(Last, First, Middle Initial)*
2. Social Security Number
3. Sex ☐ Male ☐ Female
4. Address *(Street, Apt #, P.O. Box)*
5. Date of Birth
6. Telephone Number
(City, State, ZIP Code)
7. Dependents ☐ Spouse ☐ Child ☐ Other

ILLNESS BEING CLAIMED

8. Identify Diagnosed Condition(s) Being Claimed ? *Click for Help*
9. Date of Diagnosis — Month / Day / Year

☐ Cancer *Specify Type(s):*	a)	
	b)	
☐ Beryllium Sensitivity		
☐ Chronic Beryllium Disease		
☐ Chronic Silicosis		
☐ RECA Illness *Specify Type:*		

EMPLOYMENT CLASSIFICATION

10. Identify Location or Type of Employment *(Mark any that apply)*: ?

☐ **Department of Energy Facility**
This is defined as any building, structure or premise in which the activities of federal employees, contractors or subcontractors have been conducted by or on behalf of the Department of Energy.

☐ **Atomic Weapons Facility**
This is defined as a privately-owned facility in which radioactive material has been processed for use by the United States in the manufacture of atomic weapons. (Excludes mining, milling, or transporting uranium ore)

☐ **Beryllium Vendor**
This is defined as any privately operated entity engaged in producing or processing beryllium for sale or use by the Department of Energy.

☐ **Uranium Worker**
This is defined as employment activity associated with the mining, milling or transportation of uranium ore for use in the manufacture of atomic weapons.

SPECIAL EXPOSURE COHORT

11. Prior to February 1, 1992, did you work at a gaseous diffusion plant in Paducah, Kentucky; Portsmouth, Ohio; or Oak Ridge, Tennessee? ?
☐ YES List site(s) ☐ NO

12. Prior to January 1, 1974, did you work at the Long Shot, Milrow, or Cannikin underground nuclear tests on Amchitka Island, Alaska?
☐ YES List site(s) ☐ NO

13. Are you a member of a group added to the Special Exposure Cohort by the Department of Health and Human Services?
☐ YES List group designation ☐ NO ☐ DON'T KNOW

AWARDS AND OTHER INFORMATION

14. Have you applied for an award under the Radiation Exposure Compensation Act?
☐ YES ☐ NO

15. Have you filed a lawsuit seeking either money or medical coverage for the claimed condition? ?
☐ YES ☐ NO

16. Excluding any workers' compensation awards, have you received a settlement or other award in connection with the claimed condition(s)?
☐ YES ☐ NO

17. Have you either pled guilty or been convicted of any charges connected with an application for or receipt of federal or state workers' compensation?
☐ YES ☐ NO

EMPLOYEE DECLARATION

18. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under the EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. Any change to the information provided on this form once it is submitted must be reported immediately to the District Office responsible for the administration of the claim.

I hereby make a claim for benefits under the Energy Employees Occupational Illness Compensation Program Act and affirm that the information I have provided on this form is true. Furthermore, I authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.

Claimant Signature Date

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BENEFITS UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) provides for a lump sum payment of $150,000 and medical benefits to covered employees suffering from designated illnesses incurred as a result of their exposure to radiation, beryllium, or silica while in the performance of duty for the Department of Energy and certain of its vendors, contractors and subcontractors. This legislation also provides for payment of compensation to certain survivors of these covered employees, as well as for a $50,000 lump sum payment and medical benefits to individuals, or their survivor(s), who have been found eligible for compensation under the Radiation Exposure Compensation Act (RECA).

INSTRUCTIONS FOR COMPLETING FORM EE-1

Complete all items on the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. If the requested information is not submitted, the responsible party should explain the reason for the delay and indicate when the information will be forthcoming. Submit the completed claim form and all other pertinent documentation to the appropriate district office administering the EEOICPA in the region where your most recent Energy employer is/was located.

Illness Being Claimed

Item #8 — Identify the diagnosed condition(s) being claimed. If you require additional space, attach a supplemental statement to this form. For RECA illness, list the condition(s) claimed in conjuction with the Radiation Exposure Compensation Act.

Item #9 — List the date a qualified physician first diagnosed your claimed condition(s).

Employment Classification

Item #10 — Check the box for the location and/or the type of work activities that best describes your employment situation. Mark all that apply. The Department of Energy has compiled a list of facilities categorized by location and employment designation. The list is available at the Department of Energy's web site or by contacting the regional Division of Energy Employees Occupational Illness Compensation district office.

Special Exposure Cohort

Items #11–12 — The EEOICPA allows for employees who have met particular criteria and have been employed at certain facilities to be designated as members of the Special Exposure Cohort. If you worked at any of the listed locations prior to the dates indicated, mark YES and identify the site name.

Item #13 — The EEOICPA permits the Department of Health and Human Services (HHS) to include new groups of employees in the Special Exposure Cohort. If you can identify yourself as a member of a designated group that has been added to the Special Exposure Cohort, mark YES and describe the group in which you belong.

Awards and Other Information

Item #14 — The EEOICPA provides for supplemental compensation to be paid to certain individuals who filed and received an award under RECA. You must specify whether or not you have ever applied for an award under RECA.

Item #15 — Indicate whether you have filed a civil lawsuit in regard to your claimed condition. If you mark YES, provide copies of all court documentation.

Item #16 — You must identify whether or not you have received any type of settlement or other type of award in connection with the claimed conditions(s). If you mark YES, provide copies of any relevant documentation.

Item #17 — Mark the appropriate box indicating whether or not you have ever pled guilty or been convicted of any charges connected to an application for or receipt of federal or state workers' compensation.

PRIVACY ACT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 U.S.C. 7384 et seq.) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has received will be used to determine eligibility for, and the amount of, benefits payable under the EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office of Workers' Compensation Programs and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collections actions required or permitted by the Debt Collection Act. (6) Disclosure of the claimant's social security number (SSN) or tax identification number (TIN) is mandatory. The SSN or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (7) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision. This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the EEOICPA.

PUBLIC BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 17 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address. Completed claims are to be submitted to the appropriate district office of the Office of Workers' Compensation Programs. Persons are not required to respond to the information collections on this form unless it displays a currently valid OMB number.